a shame if producers of patient educational materials continue to ignore the shortcoming of the materials available today.

These guidelines cover both the process of developing new patient information materials, as well as their content, and should be widely disseminated, so that we can produce more effective materials for the future – tailored to what our patients want and need. Some of the guidelines are simple common-sense (such as: include the publication date; develop a strategy for distribution; and publicise the availability of the materials), but others need to be repeatedly reinforced – such as the need to use patients' questions as the starting point for developing new materials; and to include checklists and questions to ask the doctor.

A major shortcoming of the book is that copies of some of the patient informational materials reviewed by the focus groups have not been included. This is a shame, because it does not allow the reader to use his own judgement to critically evaluate the materials, so that he can compare his opinion with the focus groups' findings. This could have been a valuable exercise in honing the reader's critical skills.

An additional chapter on how to actually use the patient informational materials in a clinical encounter would also have been helpful. Remember that just choosing good patient information materials is not enough – it is equally important to use it well – after all, patient education is a supplement to direct communication, not a substitute. How and when a patient education handout is presented to a patient will affect what the patient learns from it. For example, it's important to present the leaflet to the patient oneself, if possible and to emphasize its importance – personal professional endorsement of the material is powerful!

After reading this book, I would strongly suggest that the guidelines it offers are adhered to, and the development of a patient education handout – tailored to your own practise – your patients will be grateful!

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Managing Public Involvement in Healthcare Purchasing

By Carol Lupton, Stephen Peckham and Pat Taylor. Open University Press, Buckingham, 1998, £16.99 pb, £45 hb, 176pp. ISBN 0-335-19632-2 (pb), ISBN 0-335-19633-0 (hb)

In this text Carol Lupton and colleagues consider the issue of managing public involvement in health care planning in the post-reformed NHS. Following a brief introduction to the intellectual underpinnings of the move towards increased public participation in state planning, the text examines the key changes in public sector and NHS management that occurred during the 1980s and 1990s. After outlining the conceptual and institutional issues pertinent to this subject, the authors review the available empirical literature on public involvement in health care decision-making and outline a new framework for enabling this task. As a means of providing a context for their new model, the authors also consider the roles that have, and should be, played by health authorities and the public in this context. In conclusion, the authors summarize the key issues for purchasers attempting to engage individuals in the decision-making process and suggest that public involvement in health care planning is essential for the organizational health of the NHS and the wider political and social well-being of the nation.

Given the depth of its analysis and the comprehensiveness of its coverage, *Managing Public Involvement in Healthcare Purchasing* is likely to become a key text for third year undergraduates and masters students, as well as health service researchers and NHS employees, interested in this area. Although it has much to offer, from a health economist's perspective the text has a number of limitations, which are often common to work of this type. In particular, the text contains few direct references to the literature on utilitarianism and rational decision-making. In this context, the literature suggests that asking the public to become involved in NHS purchasing decisions may lead to an irresolvable conflict between the desires of

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participating individuals and the objectives of the state, which may be explained as follows. Firstly, if a participating individual is rational, the individual may attempt to maximize his or her own health status, which may involve the use of scarce NHS services that, in the main, are provided free at the point of delivery. If a health care purchaser is rational, the body may attempt to maximize the health of the population that it serves, given its annual, cash-limited budget allocation from the NHS Executive. Therefore, if the individual adopts the same approach as the health authority (that is, employs an utilitarian framework) when making recommendations about what health care services to provide, the individual may have to: (i) deny what is personally rational (that is, personal health gain maximization), or (ii) make suggestions that may be irrational for the health authority to follow (that is, decisions that do not maximize the health status of the population that it serves). In consequence, involving the public in decision-making may lead to a irresolvable conflict between the desires of participating individuals and the wider, society-level perspective that may be taken by the purchasing authority. If such a conflict does, in reality, exist, perhaps it should be asked whether public involvement in health care purchasing is appropriate, even if, on the surface, it seems to promote democracy and citizenship. Indeed, perhaps the most pertinent question in this context is not how public involvement should be managed, but how much health gain a particular society should sacrifice so that public participation may be secured.

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